Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Managed Care Services
1000 S. Fremont Ave.
Bldg. A-9 East 2nd Floor, #4
Alhambra, CA 91803-8859

Tel: (626) 299-5300
Fax: (626) 458-6761

Tangerine Brigham
Deputy Director, Managed Care

Peter Balingit, MD
Interim Chief, Managed Care

Amy Luftig-Viste
Program Director, My Health LA

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

www.dhs.lacounty.gov

PROVIDER INFORMATION NOTICE

PIN: 14 - 06

TITLE: HWLA UNMATCHED ABILITY-TO-PAY (ATP) APPLICATION

DATE: August 26, 2014

Background

Under the Healthy Way LA Health Care Initiative Unmatched Program Agreement, a patient was considered eligible for the HWLA Unmatched Program only after he or she was screened for third-party coverage by the Community Partner (CP) clinic using an ATP Application. However, beginning on August 4, 2014, some CP clinics began pre-enrolling patients into the My Health LA (MHLA) program. Other clinics will begin pre-enrolling in September 2014.

This Provider Information Notice (PIN) is to notify CPs that they may use the One-e-App Summary Sheet print out *in lieu of* the ATP application for HWLA Unmatched patients (including the Dental patients) who are pre-enrolling into the MHLA program using One-e-App (OEA), the electronic eligibility determination and enrollment system.

Provider Instructions

This is to inform you that effective immediately and until September 30, 2014, when the HWLA Unmatched program ends, it is permissible for your clinic to screen HWLA Unmatched patients utilizing OEA for the MHLA program. This means that the print-out of the OEA Application Summary Sheet may be attached to the ATP Application in lieu of filling out the ATP. This is for both new and renewing HWLA Unmatched patients between now and September 30, 2014.

If you attach the OEA Application Sheet to the ATP application, please do the following:

1. Have the ATP Application signed by the patient.
2. Complete the eligibility period on the ATP.
3. Draw a line across the top of the ATP application with the wording "SEE ATTACHED OEA SUMMARY SHEET" (see attached example).
4. Attach the OEA Application Sheet to the ATP Application.

Attaching the OEA Summary Sheet to the ATP Application will not be required after September 30, 2014, when the HWLA Unmatched program ends. On October 1, 2014, the MHLA program will begin and the ATP Application will no longer be used.

If you have any questions or need further information, please contact your Program Advocate.

Tangerine M. Brigham
Deputy Director, Managed Care Services
Los Angeles County Department of Health Services

one2app
One Stop Access to Health Insurance

Application Summary

Generated By	Ernesto Reynoso
Generated On	7/22/2014

Household Information

Application ID
Creation Date

Primary Informant Name
In Household
Entity ID
Preferred Spoken Language by Primary Informant
Preferred Written Language by Primary Informant

Application Created By
Assistor Phone Number
Assistor Location
Assistor Organization
Assistor Email
Number of Persons
Adults
Children
Unborn Children

Household Address and Contact Information

Homeless
Are your home and mailing addresses the same?
Delivery Type
Home Address 1
Home Address 2
City
State
County
Zip
Email
Home Phone
Work Phone
How would you like to be contacted?

Delivery Type
Mailing Address 1
Mailing Address 2
City
State
County
Zip

Cell Phone
Message/Emergency Phone

Adult Details

Person Sequence Number
Name
Gender
Date of Birth
Age
Place of Birth
US Citizen
Date of Entry into US
Marital Status

Person ID
Applying for Benefits
Relationship to Applicant
Have SSN
SSN

Legal Resident
PRUCOL Alien
Spouse Name

Application Summary

Race/s

Has Disability

Disability Start Date

Ever received temporary Cash assistance, SSI, Food Stamps or Medi-Cal

Name used when Cash Aid, SSI, Food Stamps or Medi-Cal receiver

Work More Than 100 Hrs

Long Term Care

Entry Date

Return Home in 6 Months

Enrolled in school fulltime

School Type

Requesting Medi-Cal coverage for unpaid expenses in the last 3 months?

Denied for any state or federal program

Employer Paid Insurance

Has a lawsuit pending due to an accident or injury?

Hospital or office visits

Other Expenses

Medical Home

Person Sequence Number

Name

Gender

Date of Birth

Age

Place of Birth

US Citizen

Date of Entry into US

Marital Status

Pregnant

Race/s

Has Disability

Disability Start Date

Ever received temporary Cash assistance, SSI, Food Stamps or Medi-Cal

Name used when Cash Aid, SSI, Food Stamps or Medi-Cal received

Work More Than 100 Hrs

Long Term Care

Entry Date

Return Home in 6 Months

Hispanic/Latino

Medi-Cal BIC Number

Name of Facility

Return Home

School Name

Prescribed Medications

Person ID

Applying for Benefits

Relationship to Applicant

Have SSN

SSN

Legal Resident

PRUCOL Alien

Spouse Name

Hispanic/Latino

Medi-Cal BIC Number

Name of Facility

Return Home

Application Summary

Enrolled in school fulltime

School Type

School Name

Requesting Medi-Cal coverage for unpaid expenses in the last 3 months?

Denied for any state or federal program

Employer Paid Insurance

Has a lawsuit pending due to an accident or injury?

Hospital or office visits

Prescribed Medications

Other Expenses

Medical Home

Child Details

Person Sequence Number

Person ID

Name

Applying for Benefits

Gender

Relationship to Applicant

Date of Birth

Have SSN

Age

SSN

Place of Birth

US Citizen

Legal Resident

Date of Entry into US

Date Legal Permanent Status Received

Marital Status

Spouse Name

Pregnant

Hispanic/Latino

Race/s

Father Living in Home

Mother Living in Home

Father Deceased

Mother Deceased

Father's Identity known

Mother's Identity known

Father's Name

Mother's Name

Custodial Parent ID (Father)

Custodial Parent ID (Mother)

Custodial Parent Name (Father)

Custodial Parent Name (Mother)

Is Father Disabled

Is Mother Disabled

Is Father Employed

Is Mother Employed

International Address (Father)

International Address (Mother)

Address1 (Father)

Address1 (Mother)

Address2 (Father)

Address2 (Mother)

City (Father)

City (Mother)

State (Father)

State (Mother)

Zip (Father)

Zip (Mother)

Has disability

Ever received temporary Cash assistance, SSI, Food Stamps or

Application Summary

Medi-Cal?

Long Term Care

School Type

School District Name

Requesting Medi-Cal coverage for unpaid expenses in the last 3 months?

Denied for any state or federal program

Employer Paid Insurance

Has an employer offered to pay all or some portion of your child's health coverage?

KP Premium Amount

EU Number

Person Sequence Number

Name

Gender

Date of Birth

Age

Place of Birth

US Citizen

Date of Entry into US

PRUCOL Alien

Marital Status

Pregnant

Race/s

Mother Living in Home

Mother Deceased

Mother's Identity known

Mother's Name

Custodial Parent ID (Mother)

Custodial Parent Name (Mother)

Is Mother Disabled

Is Mother Employed

International Address (Mother)

Address1 (Mother)

Address2 (Mother)

City (Mother)

State (Mother)

Zip (Mother)

Has disability

Ever received temporary Cash assistance, SSI, Food Stamps or Medi-Cal?

Name of Facility

School Name

PU Number

Person ID

Applying for Benefits

Relationship to Applicant

Have SSN

SSN

Legal Resident

Date Legal Permanent Status Received

Spouse Name

Hispanic/Latino

Father Living in Home

Father Deceased

Father's Identity known

Father's Name

Custodial Parent ID (Father)

Custodial Parent Name (Father)

Is Father Disabled

Is Father Employed

International Address (Father)

Address1 (Father)

Address2 (Father)

City (Father)

State (Father)

Zip (Father)

Long Term Care

School Type

School District Name

Requesting Medi-Cal coverage for unpaid expenses in the last 3 months?

Denied for any state or federal program

Employer Paid Insurance

Has an employer offered to pay all or some portion of your child's health coverage?

KP Premium Amount

EU Number

Name of Facility

School Name

PU Number

Household Relationships

Name	Relationship	Name
	Spouse	
	Parent	
	Parent	
	Spouse	
	Parent	
	Parent	
	Child	
	Child	
	Sibling	
	Child	
	Child	
	Sibling	

Income Details

Name

Income

Gross Monthly Amount

Address 1

City

Net Self Employment Income

Type of Work Indicated

Name

Income

Gross Monthly Amount

Net Self Employment Income

Type of Work Indicated

Name

Income

Gross Monthly Amount

Income Type

Frequency

Employer Name

State

Zip

Telephone

Self Employment Hours Worked

Income Type

Frequency

Self Employment Hours Worked

Income Type

Frequency

Net Self Employment Income

Type of Work Indicated

Name

Income

Gross Monthly Amount

Self Employment Hours Worked

Income Type

Frequency

Net Self Employment Income

Type of Work Indicated

Self Employment Hours Worked

Additional Household Information

Does any child listed on this application attend a school?

Does anyone listed on this application claim to be legally blind or disabled?

Eligibility Results

Name	Program_Name	Coverage_Type	Opt_Out	Reconsider	Gross Income	Net Ded"s	Net Income	Family Size	FPL %	DENIAL REASON

Notes

Application Signature Information

Program Name	Signature Type	Signature Date

Print Close